| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | X2) MULTIPLE CONSTRUCTION (X3) DATE | | | SURVEY | |
|--|--|---|-------------------------------------|-------------------|--|--------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITH | A. BUILDING 00 CO | | | ETED |
| | | 155784 | A. BUILDING | | | 05/30/ | 2012 |
| | | | B. WIN | | ADDRESS CITY STATE ZID CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | ₹ | | l | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | ELLABULTATION OFNITED | | | DOUGLAS RD | | |
| MICHIANA HEALTH AND REHABILITATION CENTER | | | | MISHA | WAKA, IN 46545 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0000 | | | | | | | |
| F0000 | Complaints IN00 IN00108956. Complaint IN00 Federal/state def allegations are circles and F323, F441, and Complaint IN00 Federal/state def allegations are circles and F441. | 108375-Substantiated. Ticiencies related to the ited at F157, F314, F315, F514. 108956-Substantiated. Ticiencies related to the ited at F157, F315, F323, Itay 29 & 30, 2012 012329 r: 155784 01002500 | F00 | 00 | This Plan of Correction is the center's credible allegation of compliance. Preparation and/o execution of this plan of correction does not constitute admissionor agreement by the provider of the truth of the fact alleged or conclusions set fort the statement of deficiencies. The plan of correctionis prepa and/or executed solely becaus is required by the provisions of federal and state law. | s s h in red se it | |
| LABORATOR | Y DIRECTOR'S OR PRO | VIDER/SUPPLIER REPRESENTATIVE'S SI | GNATURI | 3 | TITLE | | (X6) DATE |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

012329

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: 155784 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM 05/3 | TE SURVEY TPLETED 80/2012 | | |
|--------------------------|--|---|--|-------------|----------------------------|--|--|
| MICHIAN | PROVIDER OR SUPPLIER NA HEALTH AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| | Total: 72 Sample: 8 | | | | | | |
| | These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. | | | | | | |
| | Quality review completed on June 5, 2012 by Bev Faulkner, RN | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 2 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO A. BUILDING | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-----------------------------|--|----------------------|
| | | 155784 | B. WING | | 05/30/2012 |
| | PROVIDER OR SUPPLIER | EHABILITATION CENTER | 1420 E | ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| F0157 SS=D | A facility must im resident; consult and if known, no representative or member when the resident which the potential for intervention; a si resident's physic status (i.e., a defor psychosocial threatening condications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the respecified in §483. The facility must resident and, if k representative or when there is a consequence as a change in resident and paragraph (b)(1). | NE/ROOM, ETC) Inmediately inform the With the resident's physician; tify the resident's legal If an interested family In | | | |
| | Based on observation interview, the factoristic resident's family drainage at a sup | ation, record review, and cility failed to notify the or physician of a fall, or apubic urinary catheter pubic catheter not | F0157 | It is the practice of this facility the resident, resident's physic and resident's family or legal representative will be informed when there is an accident involving the resident which | ian |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 3 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|------------------------------|-----------------------|--|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | | COMPLETED |
| | | 155784 | B. WIN | | | 05/30/2012 |
| | | | D. 1111 | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | DOUGLAS RD | |
| MICHIANA HEALTH AND REHABILITATION CENTER | | | | WAKA, IN 46545 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | DATE |
| | | perly for 2 of 8 residents | | | results in injury and has the potential for requiring physicia | n |
| | reviewed for cha | inge in condition in the | | | intervention; a significant chan | |
| | sample of 8. | | | | in the residents physical, ment | |
| | (Residents #D an | nd #E) | | | or psychosocial status; a need | |
| | Findings include: | | | | alter treatment significantly; or decision to transfer or discharge the resident from the facility. | |
| | 1. On 5/29/12 at | 10:10 a.m., Resident #E | | | Corrective Action: Residents who have a suprapubic cathe | ter |
| | | bed. The resident had a | | | have been seen by the physici | |
| | suprapubic catheter(an urinary catheter | | | | Families have been informed of | |
| inserted into the bladder through the | | | | | the suprapubic catheter draina | ige |
| | abdominal area in place) in place to the | | | | and the site of insertion. All | |
| | | The resident had a | | | nurses will be re-educated abord checking the boxes on the | out |
| | | | | | physicians phone orders that | |
| | | n. There was a round area | | | indicate family was notified an | d to |
| | - | ddish/brown drainage on | | | document in the nurses notes | |
| | | spital gown. LPN #1 | | | that family and physician were | |
| | | at's gown and there was | | | notified. The night nurse on ea | ach |
| | dried brown/red | colored drainage on the | | | unit will be responsible for | an |
| | dressing approxi | mately 1.5 cm | | | The double check that physicial and family were notified. They | |
| | (centimeters) in | diameter where it was | | | will look at the green copy of the | |
| | covering the inse | ertion site. LPN #1 | | | physician phone order to ensu | |
| | removed the dres | ssing and cleansed the | | | that the nurse who wrote the | |
| | | th wound cleanser and | | | order check the box indicating | the |
| | placed a dry dres | ssing over the site. | | | physician and family were notified. Then check the nurse | |
| | | <i>5</i> | | | note to ensure it was | |
| | On 5/30/12 at 7: | 35 a.m., the resident was | | | documented. The night nurse | will |
| | | Unit Manager #1 | | | then initial the green copy that | |
| | | ssing to the suprapubic | | | indicates the checks were | |
| | | | | | completed. | |
| | | a circular area of light | | | How Others Identified: All residents will have the above | |
| | | age on the dressing | | | process completed with each | |
| | approximately th | ne size of a nickel. | | | physicians order. Residents | |
| | | | | | residing in the facility will be | |
| | | lesident #E was reviewed | | | addressed by following policy | and |
| | on 5/29/12 at 11 | :00 a.m. The resident's | | | procedure and re-educated | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 4 of 38

| | | X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY | | | í í | |
|--|--|---|--------|--------------------------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED |
| | | 155784 | B. WIN | | | 05/30/2012 |
| NAME OF I | DROWINED OR CLIDDLIED | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1420 E | DOUGLAS RD | |
| | | EHABILITATION CENTER | | | WAKA, IN 46545 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | , | DATE |
| | ~ | ed, but were not limited | | | and/or disciplinary action of employees. | |
| | to, benign prosta | | | | Preventative Measures: The | |
| | depression, perip | heral vascular disease, | | | Unit Managers (UM), Assistan | |
| | and diabetes mel | litus. The resident was | | | Director of Nursing (ADON) or | |
| | sent to the hospit | al on 5/14/12 for | | | designee will check the green | |
| | _ | suprapubic catheter on | | | phone orders to ensure they h | |
| | | ysician's order was | | | been initialed. The UM, ADOI | |
| | · | 2 to change the dressing | | | or designee will also check the nurses notes, MAR's, TAR's to | |
| | | | | | ensure documentation was | |
| | to the suprapubic catheter site daily and as | | | | completed. | |
| needed. The dressing change treatment | | | | | Monitoring: The ADON, Dire | ctor |
| was signed out as completed 5/15/12 | | | | of Nursing (DON), or designed | | |
| through 5/29/12. | | | | will check the green orders ea | l l | |
| | | | | | morning during clinical review | l l |
| | Review of the 5/2 | 2012 Nurses Progress | | | ensure they have been initiale The monitoring log will be | ea. |
| | Notes indicated a | nn entry was made on | | | checked daily for 2 weeks, 3 | |
| | 5/19/12 at 12:30 | a.m. This entry | | | times a week for 2 weeks, wee | eklv |
| | indicated the resi | dent was receiving Cipro | | | for 4 weeks, then monthly for | |
| | (an antibiotic) re | lated to the suprapubic | | | months. Trends will be review | |
| | · ′ | . An entry made on | | | in QA monthly times 3 months | 3 |
| | | .m., indicated a skin | | | and quarterly thereafter to | |
| | | completed and large | | | determine further education and/or further monitoring need | 19 |
| | | age was observed at the | | | Identified non-compliance will | |
| | | • | | | result in one to one re-educati | on |
| | | nd the open area was | | | up to and including termination | n. |
| | | a strong odor. The | | | Any identified trends will be | |
| | I - | alled and stated he wanted | | | forwarded to the administrator | |
| | | 1 at 8:00 a.m., to see | | | review and presented to QA to determine further educational |) |
| | | vere available. The next | | | needs. | |
| | entry was made of | on 5/19/12 at 1:00 p.m. | | | Systems Changes: Competer | d |
| | This entry indica | ted the resident's | | | by 6/21/2012. | |
| | suprapubic cathe | ter was not draining and | | | | |
| staff attempted to flush the catheter | | | | | | |
| multiple times. The resident's abdomen | | | | | | |
| | _ | er to touch with drainage | | | | |
| | | sertion site. The | | | | |
| | | 150111011 5110. 1110 | | | 1 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 5 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|---|---|--------|--------|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED | |
| | | 155784 | B. WIN | | | 05/30/2012 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| MICHIAN | IA HEAI TH AND RI | EHABILITATION CENTER | | | DOUGLAS RD NAKA, IN 46545 | | |
| (X4) ID | | | | ID | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION | |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | |
| | Physician was ca | alled and orders were | | | | | |
| | given for Keflex | (an antibiotic) to be | | | | | |
| | given four times | a day. An entry made on | | | | | |
| | 5/23/12 at 8:00 a | .m., indicated the | | | | | |
| | dressing to the su | aprapubic site was | | | | | |
| | changed and a la | rge amount of purulent | | | | | |
| | | esent on the old dressing | | | | | |
| | | ount if bloody drainage | | | | | |
| | | were no further entries | | | | | |
| | made after this. | | | | | | |
| | | 1 7/20/12 | | | | | |
| | | ed on 5/30/12 at 11;15 | | | | | |
| | | (Assistant Director of | | | | | |
| | • | ed the resident was | | | | | |
| | | ex for 7 days starting on | | | | | |
| | | ON indicated the | | | | | |
| | | ian should have been | | | | | |
| | | sident having continued | | | | | |
| | _ | DON indicated the | | | | | |
| | | ian should have been | | | | | |
| | had instructed. | 00 a.m., on 5/19/12 as he | | | | | |
| | nau msuucteu. | | | | | | |
| | 2. The closed re | cord for Resident #D was | | | | | |
| | | 9/12 at 2:30 p.m. The | | | | | |
| | | ses included, but were | | | | | |
| | | nal failure, history of a | | | | | |
| | | nd fracture of the neck of | | | | | |
| | | e in the leg). The resident | | | | | |
| | · · | the facility on 4/20/12. | | | | | |
| | | | | | | | |
| | Review of the 5/2 | 2012 Nursing Progress | | | | | |
| | Notes indicated a | an entry was made on | | | | | |
| | 5/7/12 at 6:45 p.i | m. This entry indicated | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 6 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: | (x2) MULTIPLE CONSTRUCTION A. BUILDING 00 | COMPLETED | | | | |
|--------------------------|--|---|--------------------------------------|--|--|--|--|
| | 155784 | B. WING | 05/30/2012 | | | | |
| | PROVIDER OR SUPPLIER NA HEALTH AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY) | S SHOULD BE COMPLETION E APPROPRIATE | | | | |
| | the resident was calling down the hall for the nurse. The resident was found sitting on the floor by his bed and stated he slipped out of his chair. Neuro checks(assessment to determine if any changes were noted in the neurological status) were initiated. The entry also indicated the resident was to be non weight bearing to his right hip. A Communication and Progress Note, dated 5/7/12, indicated the Physician was notified of the resident's fall. There was no documentation in the Nursing Progress Notes or the Communication and Progress Note to indicate the resident's family was notified of the fall. When interviewed on 5/30/12 at 12:45 p.m., the ADON indicated the resident's family should have been notified of the fall. This federal tag relates to Complaints IN00108375 and IN00108956. 3.1-5(a)(2) | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 7 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|---|---|---|--------------|---|-------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED | |
| | | 155784 | B. WIN | | | 05/30/2012 | |
| NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | (X5) | |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| | ` | | | | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | |
| F0314 SS=D | 483.25(c) TREATMENT/SV PRESSURE SO Based on the co a resident, the faresident who ent pressure sores of sores unless the demonstrates the and a resident have receives necessing promote healing prevent new sore Based on observe interview, the fact treatment and set healing related to boots to relieve prodered for 3 of for Prevalon bood facility also faile wound care treat of 3 residents revisample of 8. (Residents #B, # Findings include 1. On 5/29/12 at was observed in gauze dressing in area and a foam theel area. The reprevalon boots of | mprehensive assessment of acility must ensure that a sers the facility without does not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores ary treatment and services to prevent infection and es from developing. ation, record review, and ecility failed to provide revices to promote wound of Prevalon boots (soft pressure) were in place as 3 residents with orders at in sample of 8. The did to ensure the correct ment was rendered for 1 reviewed for wounds in the E, and #G) E 2:30 p.m., Resident #G bed. The resident had a place to the right ankle dressing in place to left esident did not have any | F03 | TAG | F 314 It is the practice of this facility that each resident who enters the facility without a pressure sore does not develous one unless the individual's clin condition demonstrates that the were unavoidable; and a resid who has pressure sores received necessary treatment and servito promote healing. Corrective Action: Residents who have orders for prevalon boots have been assessed to ensure they have the boots available, the care care planned, the CNA she indicates the resident is to weather and the times they are to on and off. Resident G was reassessed and care plans reviewed ensuring treatment is correct and reflective of currer status. How Others Identified Reisdents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. 100% autor residents with physician orders for prevalon boots | ey ent ves ces coot eet ar be | 06/21/2012 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 8 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | (X3) DATE SURVEY | | |
|--|--|---|--|---------------------------|--|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITE | LDING | 00 | COMPLETED |
| | | 155784 | A. BUI B. WIN | LDING | | 05/30/2012 |
| | | <u>I</u> | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | 1 | | |
| MICHIAN | JA HEAI TH AND R | EHABILITATION CENTER | 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | |
| | | | | | I | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | ` | ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| TAG | | The resident's heels | | IAG | completed. Ensuring care plan | |
| | | | | | and CNA shets are reflective | |
| | | the mattress. The resident | | | current status. Preventative | |
| | did not have any | Prevalon boots on. | | | Measures: The UM, ADON, o | or |
| | | | | | designee will monitor the TAR | |
| | On 5/30/12 at 9: | 20 a.m., the resident was | | | ensure the nurse is completing | g |
| | observed in bed. | The resident had a pink | | | the weekly skin assessment. | |
| | foam dressing in | place to his left heel. | | | Monitor the CNA assignment sheets to ensure the informati | on |
| | The resident was | s not wearing any | | | about the prevalone boots is | |
| | Prevalon boots a | | | | available. All nurses and CNA | √'s |
| | | | | | will be re-educated about prop | per |
| The record for Resident #G was reviewed | | | | skin assessments and skin | | |
| | | | | | checks. Also, the proper use | of |
| | on 5/29/12 at 12:30 p.m. The resident's diagnoses included, but were not limited | | | | prevalone boots. Monitoring: | |
| | • | | | | The UM, ADON, DON, or designee will monitor the | |
| | 1 | ressure, diabetes mellitus, | | | availability and use of the | |
| | and | | | | prevalon boots during their | |
| | cerebral vascula | r accident (stroke). | | | rounds. During rounds the UM | 1, |
| | | | | | ADON, DON and/or designee | will |
| | Review of the 5/ | 2012 Physician Order | | | use a monitoring log to check | |
| | Statement indica | ated there were Physician | | | three (3) residents daily for 2 weeks, weekly for 4 weeks, th | on |
| | orders for the re | sident to have Prevalon | | | monthly for 3 months. Trends | |
| | boots on while in | n bed for pressure ulcers. | | | will be reviewed in QA monthl | |
| | | an order to cleanse the left | | | times 3 months and quarterly | |
| | | s solution, apply calcium | | | thereafter to determine further | • |
| | | er with Allevyn heel | | | education and/or further | |
| | dressing daily ar | · | | | monitoring needs. Identified | nne |
| | diessing dairy ai | ia as needed. | | | non-compliance will result in c to one re-education up to and | WIIG |
| | The Strin Crist - | prorts for 4/2012 and | | | including termination. Any | |
| | | eports for 4/2012 and | | | identified trends will be forwar | ded |
| | | iewed. A Skin Grid | | | to the administrator for review | |
| | _ | cated the resident had a | | | and presented to QA monthly, | to |
| | | al thickness wound | | | determine further educational | |
| | - | hallow open area with a | | | needs. Systems Changes: Completed by 6/21/2012 | |
| | red pink center) | pressure ulcer to the right | | | Completed by 0/2 1/2012 | |
| | malleous area. | On 5/1/12 the wound | | | | |
| | measured 3 cm | (centimeters) x 2 cm A | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY |
|--|---|------------------------------|-----------------------|------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | | |
| | | 155784 | B. WIN | G | | 05/30/2012 |
| NAME OF P | PROVIDER OR SUPPLIER | | • | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | | DOUGLAS RD | |
| MICHIANA HEALTH AND REHABILITATION CENTER | | | | MISHA | NAKA, IN 46545 | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | _ | t form indicated the | | | | |
| | | stageable wound to the | | | | |
| | left heel. On 5/2 | | | | | |
| | measured 1.6 cm | x 1.6 cm. | | | | |
| | | | | | | |
| | 1 - | der was written on | | | | |
| | | ntinue all previous | | | | |
| | treatments to the | right ankle. | | | | |
| | Daview of the 5/ | 2012 Treatment Record | | | | |
| | | | | | | |
| | indicated there was a treatment to cleanse | | | | | |
| | the right ankle with normal saline, pat dry | | | | | |
| | 1 1 1 1 1 1 | opical ointment to deride | | | | |
| | · · · · · · · · · · · · · · · · · · · | rea and cover with a | | | | |
| | | 2 hours and as needed. | | | | |
| | The treatment wa | • | | | | |
| | completed on 5/1 | 1/12, 5/4/12, 5/7/12, | | | | |
| | 5/10/12, 5/13/12 | , 5/16/12, 5/19/12, | | | | |
| | 5/22/12, 5/15/12 | , and 5/28/12. | | | | |
| | W/h and instant in | .1 5/20/12 -4 11:15 | | | | |
| | | ed on 5/30/12 at 11:15 | | | | |
| | | indicated the resident | | | | |
| | | the Prevalon boots in | | | | |
| | 1 ^ | as in bed. The ADON | | | | |
| | | e wound treatment to the | | | | |
| | right malleous (a | | | | | |
| | | ne ADON indicated she | | | | |
| | interviewed staff | nurses and they | | | | |
| | indicated they ha | d been doing the | | | | |
| | treatment to the | right ankle after the area | | | | |
| | healed. The AD | ON indicated the order | | | | |
| ı | was written on 4 | /28/12 to discontinue the | | | | |
| | right ankle treatn | | | | | |
| | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 10 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | |
|--|---|------------------------------|-------------------------------------|--------------|--|-------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETED 05/30/2012 | | | | |
| | | 155784 | B. WIN | | | 05/30/ | 2012 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| MICHIAN | | EHABILITATION CENTER | | | DOUGLAS RD VAKA, IN 46545 | | |
| | | | _ | l | | ı | 215 |
| (X4) ID PREFIX | | | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | DATE |
| | 2. During orient | ation tour on 5/29/12 at | | | | | |
| | | ent #E was observed in | | | | | |
| | · · | nt had a dressing in place | | | | | |
| | | e area. The resident's | | | | | |
| | _ | evated off the bed. The | | | | | |
| | resident did not l | nave a Prevalon boot on | | | | | |
| | either foot. | | | | | | |
| | | | | | | | |
| | On 5/29/12 at 10 | :10 a.m., LPN #1 was | | | | | |
| | observed providi | ng wound care to the | | | | | |
| | resident's right heel area. The was a small | | | | | | |
| | black scabbed area to the right heel | | | | | | |
| | 0 11 | ximately 0.5 cm x 0.5 | | | | | |
| | | ling skin was intact. The | | | | | |
| | | e area with wound | | | | | |
| | | lied a dressing. The LPN | | | | | |
| | • | eatment and left the | | | | | |
| | | LPN #1 did not place | | | | | |
| | any boot on the i | resident's right foot. | | | | | |
| | 0.5/20/12 . 2 / | 25 4 11 4 | | | | | |
| | | 35 p.m., the resident was | | | | | |
| | | The resident did not | | | | | |
| | foot. | boot in place to the right | | | | | |
| | 1001. | | | | | | |
| | On 5/30/12 at 8: | 10 a.m., the resident was | | | | | |
| | | There resident had a | | | | | |
| | | to the right ankle area. | | | | | |
| | | ght foot was resting on | | | | | |
| | | The resident did not | | | | | |
| | | boot on the right foot. | | | | | |
| | | - | | | | | |
| | The record for R | esident #E was reviewed | | | | | |
| | on 5/29/12 at 11: | 00 a.m. The resident's | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 11 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|---|---|--------|-----------------------|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BU | A. BUILDING COMPLETED | | | |
| | | 155784 | B. WIN | NG | | 05/30/2012 | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | DOUGLAS RD | | |
| MICHIAN | IA HEALTH AND RI | EHABILITATION CENTER | | MISHAV | NAKA, IN 46545 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | · · · · · · · · · · · · · · · · · · · | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | DATE | |
| | _ | ed, but were not limited | | | | | |
| | ' | art failure, peripheral | | | | | |
| | · · | diabetes mellitus, and | | | | | |
| | _ | iew of 5/2012 Treatment | | | | | |
| | Record indicated | there was an order for | | | | | |
| | the resident to w | ear a Prevalon boot to the | | | | | |
| | right foot while i | n bed. There was also a | | | | | |
| | wound care orde | r for a Allevyn heel guard | | | | | |
| | to be applied to t | he right foot. | | | | | |
| | | | | | | | |
| | Review of the 5/2012 Skin Grid ulcer | | | | | | |
| | report indicated the resident had a right | | | | | | |
| | heel wound. Do | cumentation on 5/22/12 | | | | | |
| | the wound was d | escribed as suspected | | | | | |
| | | y(purple or maroon | | | | | |
| | | discolored skin or blood | | | | | |
| | | asuring 4.2 cm x 2.4 cm. | | | | | |
| | | wowg v | | | | | |
| | When interviewe | ed on 5/30/12 at 11:15 | | | | | |
| | | indicated the resident | | | | | |
| | · · · · · · · · · · · · · · · · · · · | the Prevalon boot on the | | | | | |
| | right foot when h | | | | | | |
| | 11511t 100t WINCH I | ic was in ood. | | | | | |
| | 3 During orient | ation tour on 5/29/12 at | | | | | |
| | | ent #B was observed | | | | | |
| | | chair in his room. The | | | | | |
| | _ | | | | | | |
| | | sings in place to both his | | | | | |
| | right and left fee | l. | | | | | |
| | On 5/20/12 -4 2 - | 55 mm. Davids ut //D | | | | | |
| | | 55 p.m., Resident #B was | | | | | |
| | | The resident had blue | | | | | |
| | | et. The resident did not | | | | | |
| | have any Prevalo | on boots on either foot. | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 12 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: 155784 | A. BUILDING B. WING | COMPLETED 05/30/2012 |
|---|---|---|--|
| NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STA 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIV CROSS-REFERENC | PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE PLICIENCY) (X5) COMPLETION DATE |
| | The record for Resident #B was reviewed on 5/29/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, anemia, and acute renal failure. Review of the 5/2012 Physician orders indicated there was an order written on 5/17/12 for the resident to wear Prevalon boots while in bed. There was also an order written on 5/17/12 to cleanse the areas to both heels with soap and water, pat dry, and apply Santyl and calcium alginate, then cover with a Allevyn border dressing. The 5/2012 Skin Grid reports indicated the resident had a Stage II pressure ulcer to the left heel. An entry made on 5/22/12 indicated the pressure are measured .4 cm x .4 cm. The report also indicated the resident had a Stage II pressure area to the right heel. An entry made on 5/22/12 indicated the ulcer measured 1.2 cm x 1.8 cm. When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated the resident should have had the Prevalon boots on as when he was in bed. This federal tag relates to Complaint IN00108375. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 13 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155784 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE S COMPLE 05/30/2 | ETED |
|--------------------------|--|--|---|---|----------------------------|
| MICHIAN | PROVIDER OR SUPPLIER | 1420 E | ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | 3.1-40(a)(2) | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 14 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|--|--|-------------------------|----------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETE | | | ETED | |
| | | 155784 | A. BUII B. WIN | | | 05/30/ | 2012 |
| | | | B. WIIN | _ | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DOUGLAS RD | | |
| MICHIANA HEALTH AND REHABILITATION CENTER | | | | WAKA, IN 46545 | | | |
| MICHIAN | A HEALTH AND RI | EHABILITATION CENTER | | MISHA | WARA, IN 46545 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0315 | 483.25(d) | | | | | | |
| SS=D | | , PREVENT UTI, RESTORE | | | | | |
| | BLADDER | | | | | | |
| | | sident's comprehensive | | | | | |
| | | facility must ensure that a | | | | | |
| | | ers the facility without an er is not catheterized unless | | | | | |
| | | nical condition demonstrates | | | | | |
| | | on was necessary; and a | | | | | |
| | | ncontinent of bladder | | | | | |
| | | riate treatment and services | | | | | |
| | to prevent urinar | y tract infections and to | | | | | |
| restore as much normal bladder function as | | | | | | | |
| | possible. | | | | | | |
| | Based on observa | ation, record review, and | F03 | 15 | F 315 It is the practice of this | | 06/21/2012 |
| | interview, the facility failed to ensure | | | | facility to ensure that a resider | | |
| | | ovide to treat a urinary | | | who enters the facility without | an | |
| | - | lated to not obtaining | | | indwelling catheter is not | 47 _ | |
| | | • | | | catheterized unless the reside | | |
| | | verify the correct | | | clinical condition demonstrates that catheterization was | 5 | |
| | | ent was provided for a | | | necessary; and residents who | are | |
| | urinary tract infe | ctions for 1 of 3 residents | | | incontinent of bladder receives | | |
| | reviewed for urin | nary tract infections and | | | appropriate treatment and | | |
| | catheters in the s | ample of 8. The facility | | | services to prevent UTI's. | | |
| | | ure a resident with | | | Corrective Action: 100% aud | lit | |
| | | om the use of urinary | | | on all residents who have a Fo | oley | |
| | - | | | | catheter and are on an antibio | | |
| | | essed thoroughly for 1 of | | | for a UTI. This is to ensure the | | |
| | | wed for urinary infections | | | culture and sensitivities are in | the | |
| | and catheters in t | the sample of 8. | | | chart and the appropriate | | |
| | (Resident #E) | | | | antibiotic is being given. When resident is admitted to the faci | | |
| | | | | | with a UTI, the nurse is to ensi | • | |
| | Finding include: | | | | that a culture and sensitivity a | | |
| | <i>5</i> | | | | available or obtain it from the | | |
| | During orientatio | on tour on 5/20/12 at 0.25 | | | hospital if not available. Resid | lent | |
| | - | on tour on 5/29/12 at 9:25 | | | E was reassessed ensuring | | |
| | • | E was observed in bed. | | | orders and care plans are | | |
| | | a suprapubic catheter (a | | | reflective of current status. Ho | | |
| | urinary catheter i | inserted into the bladder | | | Others Identified: 100% audi | | |
| | | | | | on all residents who have a Fo | oley | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 15 of 38

| | | | | | (X3) DATE SURVEY | |
|-----------|-----------------------|------------------------------|--------|----------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | ILDING | 00 | COMPLETED |
| | | 155784 | B. WIN | | | 05/30/2012 |
| NAME OF I | DROVIDED OD GUDDI IED | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | 1 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1420 E | DOUGLAS RD | |
| | | EHABILITATION CENTER | | | NAKA, IN 46545 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | TE COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 5.112 |
| | through the abdo | minal area) in place. | | | catheter and are on an antibio for a UTI were reviewed to ens | |
| | | | | | appropriate orders and care pl | |
| | On 5/29/12 at 10 | :10 a.m., Resident #E | | | are reflective of current status. | |
| | was observed in | bed. The resident had a | | | Preventative Measures: All | |
| | suprapubic cathe | ter (an urinary catheter | | | nurses will be educated to che | I |
| | inserted into the | bladder through the | | | the culture and sensitivity repo | |
| | | n place) in place to the | | | to ensure the proper antibiotic | |
| | | The resident had a | | | being given. Also, educated the upon each admission, if the | lat |
| | | There was a round area | | | resident has a UTI, there is to | be |
| | | dish/brown drainage on | | | a culture and sensitivity report | |
| | | spital gown. LPN #1 | | | not, they are to obtain one from | m |
| | | | | | the hospital. Monitoring: The | |
| | | t's gown and there was | | | UM, ADON, DON, or designed | |
| | | colored drainage on the | | | will use the monitoring log to | |
| | dressing approxi | - | | | ensure all residents who have Foley catheter and a UTI, have | I |
| | | diameter where it was | | | sensitivity report in their chart. | |
| | covering the inse | ertion site. LPN #1 | | | The UM, ADON, DON and/or | |
| | removed the dres | ssing and cleansed the | | | designee will use a monitoring | log |
| | insertion site wit | h wound cleanser and | | | to check daily, for 2 weeks, 3 | |
| | placed a dry dres | sing over the site. | | | times a week for 2 weeks, week | |
| | | | | | for 4 weeks, then monthly for 3 months new antibiotic orders f | |
| | On 5/30/12 at 7:3 | 35 a.m., the resident was | | | residents with foley caths. | |
| | | Unit Manager #1 | | | Trends will be reviewed in QA | |
| | | sing to the suprapubic | | | monthly times 3 months and | |
| | | a circular area of light | | | quarterly thereafter to determine | |
| | | · · | | | further education and/or further | er |
| | | age on the dressing | | | monitoring needs. Identified non-compliance will result in o | ine |
| | approximately th | e size of a nickel. | | | to one re-education up to and | |
| | m 10 5 | :1 . //- | | | including termination. Any | |
| | | esident #E was reviewed | | | identified trends will be forward | |
| | | 00 a.m. The resident's | | | to the administrator for review | |
| | | ed, but were not limited | | | and presented to QA to determ | nine |
| | to, urinary tract i | nfection, high blood | | | further educational needs. Systems Changes: | |
| | pressure, periphe | eral vascular disease, and | | | Completed by 6/21/2012 | |
| | diabetes mellitus | . The resident was sent | | | 33pi0.03 5, 0/2 1/20 12 | |
| | to the hospital or | 1 4/30/12 and returned to | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 16 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 00 | COM | TE SURVEY MPLETED |
|--------------------------|---|---|---------------------------------|---|----------|----------------------------|
| | | 155784 | B. WING | | — 05/3 | 30/2012 |
| | PROVIDER OR SUPPLIER | EHABILITATION CENTER | 1420 E | ADDRESS, CITY, STATE, ZIP O DOUGLAS RD WAKA, IN 46545 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | the facility on 5/2 | 2/12. | | | | |
| | order form indicate for the resident to antibiotic) 500 m 10 days to treat at Review of the 5/2 Summary report urinalysis was poinfection and the pending. The suresident was star milligrams once Results of the hoculture were not record at the time of the culture and to the facility on request The fin report was compresults were posi 100,000 proteus The sensitivity resident to the sensitivity resident. | 2/12 hospital transfer ated orders were written to receive Levaquin (an atilligrams once a day for a urinary tract infection. 2/12 hospital Discharge indicated the resident's ostitive for an urinary tract culture results were mmary also indicated the ted Levaquin 500 daily for ten days. spital urinalysis and available in the resident's et of review. The results desensitivity were faxed 5/29/12 at 2:26 per at culture and sensitivity leted on 5/4/2012. The tive for greater then mirabilis (an infection). Export indicated proteus distant to Levofloxacin | | | | |
| | reviewed. There 4/9/12 at 10:00 a the resident state | ing Progress Notes were was an entry made on .m. The entry indicated d his Foley catheter was Toley was flushed to make | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 17 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155784 | A. BUILDING B. WING | | COMPLETED 05/30/2012 | | |
|---------------|----------------------|--------------------------------|---------------------|--------|--|---|------------|
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | - |
| NAME OF P | PROVIDER OR SUPPLIER | | | | DOUGLAS RD | | |
| | IA HEALTH AND RE | EHABILITATION CENTER | | | NAKA, IN 46545 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | COMPLETION |
| IAG | | LSC IDENTIFYING INFORMATION) | | TAG | BEIGENCI | | DATE |
| | _ | t. The Foley bag was | | | | | |
| | _ | and the physician was | | | | | |
| | | instructed to recheck in | | | | | |
| | | ext entry in the Nursing | | | | | |
| | _ | vas made at 11:30 a.m. | | | | | |
| | | ted the resident's Foley | | | | | |
| | | bloody and the resident | | | | | |
| | • | arning at the catheter | | | | | |
| | | ne physician was called | | | | | |
| | | aiting for a response from | | | | | |
| | | next entry was made at | | | | | |
| | _ | was no documentation | | | | | |
| | | of the Foley catheter | | | | | |
| | _ | ext entry was made on | | | | | |
| | | a.m. There was no | | | | | |
| | | e resident's urine or his | | | | | |
| | complaints of but | rning. | | | | | |
| | | ing Progress Notes were | | | | | |
| | | was an entry made on | | | | | |
| | | .m. This entry indicated | | | | | |
| | • | rapubic catheter was | | | | | |
| | occluded and stat | ff were unable to flush | | | | | |
| | | ge amounts of drainage | | | | | |
| | | suprapubic site and the | | | | | |
| | | had a strong odor. The | | | | | |
| | | tified and he instructed | | | | | |
| | | back at 8:00 a.m. to see | | | | | |
| | which urologist v | were available. The next | | | | | |
| | entry was made o | on 5/19/12 at 1:00 p.m. | | | | | |
| | This entry indicate | ted the resident's | | | | | |
| | suprapubic cathet | ter was not draining and | | | | | |
| | Keflex (an antibio | otic) was to be started | | | | | |
| | and a urethra Fol | ey was inserted. The | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 18 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784 A. BUILDING A. WING | COMPLETED 05/30/2012 |
|---|-----------------------|
| B. WING | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO. 1420 E DOUGLAS RD MICHANIA LIFATTI AND DELIABILITATION CENTED | ODE |
| MICHIANA HEALTH AND REHABILITATION CENTER MISHAWAKA, IN 46545 | <u>,</u> |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOOTH CROSS-REFERENCED TO THE AFTER THE PROPERTY OF THE | OULD BE COMPLETION |
| entry also indicated the resident's abdomen was red and tender and drainage was noted from the incision. The next entry was made on 5/19/12 at 11:00 p.m., and this entry indicated the resident remained on antibiotics for redness to the abdomen. The next entry in Nursing Progress Notes was made on 5/22/12 at 1:00 a.m. This entry indicated the catheter was draining clear yellow urine. An entry made on 5/23/12 at 8:00 a.m., indicated the dressing to the resident's suprapubic catheter insertion site was changed and a large amount of purulent drainage was noted on the old dressing with a small amount of bloody drainage mixed in. The next entry in the Nursing Progress notes was not made until 5/29/12. Review of the 5/2012 Physician orders indicated an order was written on 5/19/12 to discontinue the Cipro (an antibiotic) and start Keflex 500 milligrams twice day for 7 days. The order for the Cipro was initially written on 5/14/12 after the resident's suprapubic catheter insertion. When interviewed on 5/29/12 at 3:30 p.m., LPN #1 indicated he was caring for the resident on 5/19/12. The LPN indicated the resident had Foley catheter inserted also on 5/19/12. The LPN indicated the resident had Foley catheter inserted also on 5/19/12. The LPN indicated the resident had Foley catheter inserted also on 5/19/12. The LPN | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 19 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | 00 | (X3) DATE COMPL | |
|-------------|---------------------|---|----------|------------|---|--------------------|------------|
| 11112 12111 | or conditions | 155784 | | LDING | | 05/30/ | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | ROVIDER OR SUPPLIER | | | | DOUGLAS RD | | |
| MICHIAN | IA HEALTH AND R | EHABILITATION CENTER | | MISHAV | NAKA, IN 46545 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE. | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | catheter replaced | ident had his suprapubic | | | | | |
| | cameter replaced | i arter tilat. | | | | | |
| | When interviewe | ed on 5/29/12 at 3:40 | | | | | |
| | | indicated the resident | | | | | |
| | - | oic catheter replaced on | | | | | |
| | 5/21/12. The AI | OON indicated there was | | | | | |
| | no documentatio | n of this or follow up | | | | | |
| | assessment of the | is. | | | | | |
| | | | | | | | |
| | | ed on 5/30/12 at 11:15 | | | | | |
| | • | indicated nursing staff | | | | | |
| | | in the Nursing Progress ft for 72 hours or until | | | | | |
| | | olves when there is a | | | | | |
| | change in condit | | | | | | |
| | • | ould have been done | | | | | |
| | | 0/12 when blood was | | | | | |
| | | lent's Foley catheter | | | | | |
| | drainage bag. Tl | ne ADON also indicated | | | | | |
| | the same follow | up charting should have | | | | | |
| | been done after t | he drainage was noted on | | | | | |
| | 5/23/12. | | | | | | |
| | 11 T | 1 5/00/10 / 2 22 | | | | | |
| | | ed on 5/29/12 at 3:30 | | | | | |
| | | indicated the resident | | | | | |
| | | ck to the facility on sician orders to receive | | | | | |
| | | illigrams. The ADON | | | | | |
| | • | ility did not follow | | | | | |
| | | fy the culture and | | | | | |
| | _ | s to properly treat the | | | | | |
| | resident's urinary | | | | | | |
| | | | | | | | |
| | | | <u> </u> | | | | l |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 20 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 05/30/2012 |
|--------------------------|------------------------------------|--|--|--|---------------------------------------|
| | PROVIDER OR SUPPLIEI | R EHABILITATION CENTER | 1420 E | ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | This federal tag IN00108375 and | relates to Complaints 1 IN00108956. | | | |
| | 3.1-41(a)(2) | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 21 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
|--|---------------------|--------------------------------|--------------|--|----------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | 00 | COMPLETED | |
| 155784 | | B. WING | | 05/30/2012 | |
| NAME OF I | PROVIDER OR SUPPLIE | D | STREE | ET ADDRESS, CITY, STATE, ZIP CODE | • |
| NAME OF I | FROVIDER OR SUFFLIE | K | 1420 | E DOUGLAS RD | |
| _ | | REHABILITATION CENTER | MISH | HAWAKA, IN 46545 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F0323 | 483.25(h) | DENT | | | |
| SS=G | FREE OF ACCI | PERVISION/DEVICES | | | |
| | | t ensure that the resident | | | |
| | I | nains as free of accident | | | |
| | | ossible; and each resident | | | |
| | | ate supervision and | | | |
| | assistance devi | ces to prevent accidents. | | | |
| | Based on observ | vation, record review, and | F0323 | F 323 It is the practice of this | 06/21/2012 |
| | interview, the fa | cility failed to ensure fall | | facility to ensure that each | |
| | prevention inter | ventions were in place for | | resident receives adequate supervision and assistance | |
| | resident's identi | fied as fall risks related to | | devices to prevent accidents. | |
| | alarms not in pla | ace which resulted in | | Corrective Action: 100% au | |
| | • | staples for 1 of the 3 who | | of all residents with alarms to | |
| | | lered interventions in | | ensure they are in place, care | 9 |
| | place for falls. | icida interventions in | | plannded, and on the CNA | 111 |
| | • | 4D 1 4D) | | assignment sheet. 100% aud | |
| | (Residents #H, # | #B, and #D) | | all residents who have had a within the last 30 days to ens | |
| | Findings include | a: | | care plans are updated and interventions are in place. Ho | |
| | 1. During orient | ation tour on 5/29/12 at | | Others Identified: 100% aud all residents with alarms. | dit of |
| | _ | lent #H was not observed | | Residents residing in the faci | lity |
| | - | NA#1 was standing in the | | will be addressed by following | |
| | | ident's bed. The bathroom | | policy and procedure and | |
| | 1 | t completely closed. The | | re-educated and/or disciplina | - |
| | | | | action of employees whom a found to not follow | e |
| | | the resident was in the | | policy.Preventative Measure | s: |
| | | resident was not in view | | Re-educate all nursing staff of | |
| | | this time, Unit Manager | | residents who are at risk for | |
| | #1 indicated Res | sident #H had frequent | | falling, proper use of bed alar | ms |
| | falls and recentl | y was sent the hospital | | and proper procedure for | |
| | Emergency Roo | m for a head injury | | resident's who are at risk for | |
| | sustained during | g a fall. | | and definition of fall and follow | _ |
| | | - | | plan of care for those residen Monitoring: The UM, ADON | |
| | The record for F | Resident #H was reviewed | | DON, or designee will use the | |
| | | 1:10 a.m. The resident | | monitoring log to ensure all | |
| | 011 3/30/12 at 10 | o. 10 a.iii. The resident | | alarms are in place for those | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 22 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784 | (X2) MULTIPLE CC A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 05/30/2012 |
|--------------------------|---|--|---|---------------------------------------|
| | PROVIDER OR SUPPLIER NA HEALTH AND REHABILITATION CENTER | STREET A 1420 E | ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | was admitted to the facility on 5/9/12. The resident was admitted from the hospital. The resident's diagnoses included, but were not limited to, Alzheimer's dementia, congestive heart failure, and high blood pressure. Review of the resident's current care plans indicated a care plan was initiated on 5/12/12. The care plan indicated the resident was at risk for falls or injury related to being unsteady, a diagnosis of dementia, receiving diuretics, narcotics, antidepressants and cardiovascular medications. The resident also had exhaustion and weakness. Care plan interventions included for one person assist to be provided for increased supervision and the assist of one staff for ambulation and transfers. Care plan interventions included chair alarm, bed alarm, floor mat and to lock the bed wheels. The care plan indicated the resident had two falls on 5/10/12 and one fall on 5/19/12. An IDT (Interdisciplinary Team) progress note was made on 5/10/12. The note indicated the resident was an "extreme fall risk" and had bed and chair alarms in place. The 5/2012 Nursing Progress Notes were reviewed. An entry made on 5/11/12 | | residents who have an order. The UM, ADON, DON and/or designee will use a monitoring to check daily those residents with alarms. Monitoring log to check that those residents wh have alarms are care planned and on the CNA assignment sheet. Monitoring log to ensure that any resident with a fall, had care plan update with an intervention. This will be monitored at the DCR, (daily clinical review) meeting. Trend will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in to one re-education up to and including termination. Any identified trends will be forwar to the administrator for review and presented to QA monthly, determine further educational needs. Systems Changes: Completed by 6/21/2012 | ds y |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 23 of 38

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784 | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 05/30/2012 |
|--------------------------|---|--|--|---|---------------------------------------|
| | PROVIDER OR SUPPLIER | EHABILITATION CENTER | 1420 E | NDDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| | the resident fell out the hospital o | Progress note indicated on 5/10/12 and was sent emergency room and as to a laceration on the | | | |
| | completed at 9:0 resident fell and | ident Transfer Form, 0 a.m., indicated the sustained a laceration to | | | |
| | the posterior scalp area and she complained of pain in her pelvis and had an abrasion to the left elbow. | | | | |
| | indicated the res the floor next to was confused an ambulate indepe a laceration to th skin tear to the le | lent form, dated 5/10/12, ident was found laying on her dresser. The resident d had attempted to ndently. The resident had e back of the head and a eft elbow. The resident ospital Emergency Room | | | |
| | | ergency Room Discharge cated staples were used to wound. | | | |
| | p.m., the ADON was a fall risk an chair and bed ala indicated the res 5/10/12 and was | ed on 5/30/12 at 12:55 indicated the resident ad interventions included arms. The ADON ident had two falls on placed on 15 minute ON indicated the resident | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 24 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784 | | A. BUILDING B. WING | | | COMPLETED 05/30/2012 | | |
|---|---|--|--|---------------------|---|---|----------------------------|
| | PROVIDER OR SUPPLIER | EHABILITATION CENTER | | 1420 E | ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| | not have been left. The ADON also the fall of 5/10/12 facility identified alarm was not in fall. She indicate observed to be or resident's room. staff were disciple alarms were in place. On 5/29/12 at was observed sittle his room. The resultant in place. On 5/30/12 at 8:00 observed sitting in the lounge area resident did not have the control of the | The ADON indicated ined for not assuring the ace. 2:45 p.m., Resident #B ing in a wheel chair in sident did not have an There was no alarm in the resident's room. 00 a.m., the resident was n wheel chair at a table a on the unit. The have an alarm in place esident #B was reviewed to p.m. The resident's ed, but were not limited itabetes mellitus, and high ted on 4/17/12 indicated at risk for falls or injury tion, weakness, and rescular medications. | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 25 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784 | | A. BUILDING B. WING | | | COMPLETED 05/30/2012 | | |
|---|---|--|--|---------------------|--|----|----------------------------|
| | PROVIDER OR SUPPLIER | EHABILITATION CENTER | | 1420 E | ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) rvention for the resident | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | | arm was added to the | | | | | |
| | reviewed. An en indicated the resi Resident #B noti resident was on t wheelchair. The | he floor in front of the resident denied in and was able to move | | | | | |
| | a.m., the ADON intervention for a in place was added of care on 5/19/1 | wheel chair alarm to be ed to the resident's plan 2 and the resident should ir alarm in place when he | | | | | |
| | reviewed on 5/29 resident was adm 4/20/12. The resincluded, but were | cord for Resident #D was 7/12 at 2:30 p.m. The itted to the facility on ident's diagnoses re not limited to, right ary retention, and skin | | | | | |
| | Notes indicated a 5/7/12 at 6:45 p.r. | 2012 Nursing Progress on entry was made on m. This entry indicated calling down the hall for | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 26 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784 | | A. BUILDING B. WING | COMPLETED 05/30/2012 |
|---|---|--|----------------------|
| | PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | BE COMPLETION |
| | the nurse. The resident was found sitting on the floor by his bed and stated he slipped out of his chair. Neuro checks(assessment to determine if any changes were noted in the neurological status) were initiated. The entry also indicated the resident was to be non weight bearing to his right hip. A care plan initiated on 4/21/12 indicated the resident was at risk for falls or injury related to a right hip fracture, syncope, and a history of a ground level fall. Care plan interventions included for the resident to have the assistance of two staff for ambulation and transfers. No other interventions were checked on the care plan. When interviewed on 5/30/12 at 12:45 p.m., the ADON indicated she was not aware of the resident's fall on 5/7/12. The ADON indicated care plan interventions should have been put into place at that time. The ADON indicated she felt an alarm should have been initiated at this time due to the resident making attempts to transfer and still having orders for non weight bearing due to his recent hip fracture and non weight bearing status. This federal tag relates to Complaints IN00108375 and IN00108956. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 27 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155784 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM | TE SURVEY MPLETED 30/2012 | | |
|--------------------------|--|---|---|-----------|----------------------------|--|--|
| | PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| | 3.1-45(a)(2) | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 28 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|--|---|--------|-------|---|--------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | ETED |
| | | 155784 | B. WIN | G | | 05/30/ | 2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | ADDRESS, CITY, STATE, ZIP CODE | | |
| MICHIAN | A HEALTH AND D | EHABILITATION CENTER | | | DOUGLAS RD WAKA, IN 46545 | | |
| | | | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0441 | 483.65 | NITO OF BREVENT | | | | | |
| SS=D | | NTROL, PREVENT | | | | | |
| | SPREAD, LINEN | | | | | | |
| | The facility must establish and maintain an Infection Control Program designed to | | | | | | |
| | | anitary and comfortable | | | | | |
| | | to help prevent the | | | | | |
| | | d transmission of disease | | | | | |
| | and infection. (a) Infection Control Program | | | | | | |
| | | | | | | | |
| | | | | | | | |
| The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | infections in the facility; (2) Decides what procedures, such as | | | | | | |
| | ` ' | • | | | | | |
| | | be applied to an individual | | | | | |
| | resident; and | ecord of incidents and | | | | | |
| | · · | s related to infections. | | | | | |
| | corrective action | 3 related to infections. | | | | | |
| | (b) Preventing S | pread of Infection | | | | | |
| | (1) When the Inf | ection Control Program | | | | | |
| | determines that | a resident needs isolation to | | | | | |
| | prevent the spre | ad of infection, the facility | | | | | |
| | must isolate the | | | | | | |
| | · , | nust prohibit employees with a | | | | | |
| | | isease or infected skin | | | | | |
| | | ect contact with residents or | | | | | |
| | | ct contact will transmit the | | | | | |
| | disease. | oust require staff to wash their | | | | | |
| | • • | direct resident contact for | | | | | |
| | | hing is indicated by accepted | | | | | |
| | professional pra | • | | | | | |
| | | | | | | | |
| | (c) Linens | | | | | | |
| | Personnel must handle, store, process and | | | | | | |
| transport linens so as to prevent the sprea | | so as to prevent the spread | | | | | |
| | of infection. | | | | | | |
| | Based on observ | vation, record review, and | F04 | 41 | F 441 It is the practice of this | | 06/21/2012 |
| | interview the fac | cility failed to ensure | | | facility to establish and mainta | ın | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 29 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|--------------------------------|--------|--|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIT | a. Building 00 | | | ETED |
| | | 155784 | | | | 05/30/ | 2012 |
| | | | B. WIN | _ | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | | | |
| MICHIAN | | REHABILITATION CENTER | | 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | |
| | NA FICAL I FI AND R | LE IABILITATION CENTER | | IVIIONA | VVANA, IIV 40040 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | • | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | _ | TAG | | | DATE |
| | | as completed after wound | | | an infection control program | | |
| | care was provide | ed for 1 of 3 residents | | | designed to provide a safe, sanitary and comfortable | | |
| | observed with w | younds in the sample of 8. | | | environment and to help preven | ent | |
| | (Resident #E) | | | | the development and | | |
| | (LPN #1) | | | | transmission of disease and | | |
| | | | | | infection | | |
| | Findings include | . | | | Corrective Action: The nurs | | |
| | i manigs merudo | J. | | | was immediately education or | า | |
| | On 5/29/12 at 10:10 a.m., LPN#1 was observed rendering wound care to Resident #E. The resident was in bed and | | | | handwashing and infection | | |
| | | | | | control. Resident "E" was not affected by this practice | | |
| | | | | | How Others Identified: | | |
| | | | | | Residents residing in the facil | itv | |
| | was wearing a h | ospital gown. The LPN | | | will be addressed by following | | |
| | put a pair of disp | posable gloves on then | | | policy and procedure and | | |
| | | ives and exited the room | | | re-educated and/or disciplinar | | |
| | | cissors. The LPN | | | action of employees whom ar | е | |
| | | esident's room and put a | | | found to not follow policy. | | |
| | | • | | | Preventive Measures: | _ | |
| | | ves on. The LPN did not | | | Re-educate all nursing staff o proper had washing technique | | |
| | | or use hand sanitizer | | | frequency, and expectation fo | | |
| | | ne second pair of gloves | | | infection control. | • | |
| | | fted the hospital gown up | | | Monitoring: The UM, ADON | , | |
| | to expose the ab | domen. The resident had | | | ETD, DON, or designee will | | |
| | a suprapubic (a | urinary catheter inserted | | | monitor one nurse per day for | | |
| | through the abdo | ominal wall into the | | | proper technique and frequen | су | |
| | 1 | was a square gauze | | | of hand washing during a | | |
| | | ver the catheter insertion | | | treatment. Both the observer the nurse will sign the paper t | | |
| | | dried, reddish/brown | | | indicates the hand washing | ııaı | |
| | | * | | | procedure was done correctly | '. | |
| | _ | area of the hospital gown | | | One nurse per day for 2 week | | |
| | | e insertion site. The area | | | one nurse 3 times per week, | | |
| | was approximately 2.5 cm (centimeters) | | | | weekly for 4 weeks, then mon | ithly | |
| | in diameter. LP | N #1 removed the | | | for 3 months. Trends will be | | |
| | dressing and cleansed the site with a gauze moistened with wound cleanser. | | | | reviewed in QA monthly times | | |
| | | | | | months and quarterly thereaft | er to | |
| | | emoved his gloves and put | | | determine further education and/or further monitoring need | de | |
| | | and proceeded to cleanse | | | Identified non-compliance will | | |

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--------|---------------|--|--------|--------------------|
| AND PLAN | OF CORRECTION | | A. BUI | LDING | 00 | | |
| | | 155784 | B. WIN | | | 05/30/ | 2012 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| MICHIAN | | EHABILITATION CENTER | | | DOUGLAS RD WAKA, IN 46545 | | |
| | | | | | WARA, IN 40040 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| IAG | | I time and then applied a | | IAG | result in one to one re-educati | | DATE |
| | | ing over the catheter | | | up to and including termination | | |
| | | I taped the dressing in | | | Any identified trends will be | | |
| | | then removed his gloves | | | forwarded to the administrator | for | |
| | _ | ir on. The LPN did not | | | review and presented to QA monthly, to determine further | | |
| | | use hand sanitizer at this | | | educational needs. | | |
| | time. | use name samuzer at tims | | | Systems Changes: Complete | ed | |
| | unic. | | | | by 6/21/2012 | | |
| | LPN #1 then place | ced a pillow under the | | | | | |
| | _ | oot and cut off the | | | | | |
| | _ | ght heel area. There was | | | | | |
| | a foam protector wrapped with gauze on | | | | | | |
| | • | was a dried intact black | | | | | |
| | | proximately 0.5 cm | | | | | |
| | | .5 cm in to the right heel | | | | | |
| | | viped the wound area | | | | | |
| | | nser and a gauze. The | | | | | |
| | | ed his gloves and left the | | | | | |
| | | o the Nurses station on | | | | | |
| | the unit. The LPI | N did not wash his hands | | | | | |
| | or use hand sanit | izer before exiting the | | | | | |
| | room. LPN #1 o | pened the door of the | | | | | |
| | Medication Roor | n and obtained a dressing | | | | | |
| | from the treatme | nt cart that was in the | | | | | |
| | room and exited | the Medication Room | | | | | |
| | and walked back | into the resident's room. | | | | | |
| | The LPN did not | wash his hands or use | | | | | |
| | hand sanitizer wl | hen entering the resident's | | | | | |
| | room. The LPN | put a pair of disposable | | | | | |
| | gloves and proce | eded to place the | | | | | |
| | dressing over the | resident's heel wound | | | | | |
| | and wrapped the | wound. | | | | | |
| | | | | | | | |
| | The LPN finished | d the wound care | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 31 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784 | | A. BUILDING B. WING | | | COMPLETED 05/30/2012 | | |
|---|--|---|--|---------------------|---|---|----------------------------|
| | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | 1420 E | NDDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| | right hand in the wrote the date on The LPN then too left hand and wro suprapubic cather then removed the resident's right le the trash can in the exited the resident the Nurse station his hands or applexiting the resident to not some station his hands or applexiting the resident to, urinary tract in mellitus, and pering Review of the resculture obtained ourine culture was mirabilis (a bacter when interviewe a.m., LPN #1 indicated have been done period to the period of the LPN indicated have been done period on the color of the LPN indicated have been done period on the color of the LPN indicated have been done period on the color of the LPN indicated have been done period on the color of the color of the LPN indicated have been done period on the color of the c | d on 5/29/12 at 10:45 icated hand washing is and after treatments. ed hand washing should prior to leaving the d on 5/30/12 at 11:15 indicated hand washing | | | | | |
| | | done after the wound | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 32 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 05/30/2012 | | | |
|---|------------------------------------|--|---|--|----------------------|--|--|
| | PROVIDER OR SUPPLIER | EHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| | the gloves in the | when the nurse removed resident's room. | | | | | |
| | This federal tag IN00108375 and | relates to Complaints I IN00108956. | | | | | |
| | 3.1-18(1) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 33 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|---|--|---|---|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RUILDING | A. BUILDING 00 COMPLETI | |
| | | 155784 | B. WING | | 05/30/2012 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | DOUGLAS RD | |
| MICHIAN | IA HEAI TH AND F | REHABILITATION CENTER | | WAKA, IN 46545 | |
| | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F0514 | 483.75(I)(1) | | | | |
| SS=D | RES | MDI ETE MOOUBATE MOOE | | | |
| | SSIBLE | MPLETE/ACCURATE/ACCE | | | |
| | | t maintain clinical records on | | | |
| | | accordance with accepted | | | |
| | | indards and practices that are | | | |
| | | rately documented; readily | | | |
| | accessible; and | systematically organized. | | | |
| | | | | | |
| The clinical record must contain sufficient | | | | | |
| | information to identify the resident; a record | | | | |
| | | s assessments; the plan of | | | |
| | | es provided; the results of any creening conducted by the | | | |
| | State; and prog | • | | | |
| | i | | F0514 | F 514 It is the practice of this | 06/21/2012 |
| | | vation, record review, and | 10314 | facility to maintain clinical reco | |
| | · · | acility to maintain | | on each resident in accordance | |
| | complete and ac | ccurate clinical records | | with accepted professional | |
| | related to transc | ription of physician | | standards and practices that a | ıre |
| | orders on the M | edication and Treatment | | complete; accurately | |
| | Records for 2 of | f 7 residents reviewed for | | documented; readily accessib | le; |
| | clinical record d | locumentation in the | | and systematically | |
| | sample of 8. | | | organized.Corrective Action: | |
| | (Residents #E a | nd #C) | | 100% audit of all admissions a re-admissions in the past 14 d | |
| | (Residents #E a. | nd #G) | | to ensure all medication have | ays |
| | F: 1: : 1 1 | | | been transcribed accurately. | AII I |
| | Findings include | e: | | physicians orders will be doub | |
| | 1 0 5/20/12 | . 2 2 2 P . 1 | | checked by the night nurse. T | hey |
| | | at 2:30 p.m., Resident #G | | will look at the green copy of t | |
| | was observed in | bed. The resident had a | | physician phone order to ensu | ire |
| | gauze dressing i | in place to the right ankle | | that the nurse who wrote the | 4h a |
| area and a foam dressing in place to left heel area. The record for Resident #G was reviewed on 5/29/12 at 12:30 p.m. The resident's | | | order transcribed the order to MAR/TAR. The night nurse w | | |
| | | | then initial the green copy that | | |
| | | | indicates the checks were | | |
| | | | completed.How Others | | |
| | | | Identified: All residents will h | ave | |
| | | ded, but were not limited | | the above process completed | |
| | uiagnoses metu | ucu, but were not milled | | with each physicians order. | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 34 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|------------------------------|--------------------------|--------|---|---------------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETED | | | COMPLETED |
| | | 155784 | | | | 05/30/2012 |
| | | | B. WIN | | ADDRESS OF STATE ZID CODE | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAIOLIIAN | IA LIEALTII AND D | | | | DOUGLAS RD | |
| MICHIAN | IA HEALTH AND R | EHABILITATION CENTER | | MISHA | WAKA, IN 46545 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | to, high blood pressure, diabetes mellitus, | | | | Residents residing in the facility | ty |
| | and | | | | will be addressed by following | |
| | cerebral vascula | r accident (stroke). | | | policy and procedure and | |
| | cereorar vascarar | r decident (stroke). | | | re-educated and/or disciplinary | • |
| | D : 0.1 5/2012 Pl : : 0.1 | | | | action of employees. Monitorin The ADON, Director of Nursing | |
| | | 2012 Physician Order | | | (DON), or designee will check | - I |
| | | ated there were Physician | | | green orders each morning | |
| | | sident to have Prevalon | | | during clinical review to ensure | e |
| | boots on while in | n bed for pressure ulcers. | | | they have been initialed. The | • • • • • • • • • • • • • • • • • • • |
| | There was an ord | der initially written on | | | Managers (UM), Assistant | |
| | 4/14/12 to cleanse the right medial ankle with normal saline, pat dry, apply Santyl, | | | | Director of Nursing (ADON) or | |
| | | | | | designee will check the green | |
| | | yn heel and Surgilast | | | phone orders to ensure they h | • • • • • • • • • • • • • • • • • • • |
| | dressing daily ar | | | | been initialed. The UM, ADON or designee will also check the | |
| | dicssing daily an | id as needed. | | | nurses notes, MAR's, TAR's t | |
| | | 1,0040 | | | ensure documentation was | |
| | | der written on 4/28/12 to | | | completed. The monitoring log | g |
| | discontinue all tr | reatments to the right | | | will be checked daily, for 2 we | eks, |
| | ankle wound. R | eview of the 4/2012 | | | 3 times a week for 2 weeks, | |
| | Treatment Recor | rd indicated "D/C" was | | | weekly for 4 weeks, then mont | thly |
| | written in colum | n for the right ankle | | | for 3 months. Trends will be | 2 |
| | treatment starting | - | | | reviewed in QA monthly times months and quarterly thereafter | |
| | | 8 | | | determine further education | 51 10 |
| | Pavian of the 5/ | 2012 Treatment Record | | | and/or further monitoring need | ls. |
| | | | | | Identified non-compliance will | |
| | | vas a treatment to cleanse | | | result in one to one re-education | on |
| | · | ght ankle and right chest | | | up to and including termination | ١. |
| | | ne, pat dry, and apply | | | Any identified trends will be | , |
| | 1 * | a and then cover with a | | | forwarded to the administrator | TOT |
| | Telfa dressing, c | change every 72 hours and | | | review and presented to QA monthly, to determine further | |
| | as needed. The o | order for the above | | | educational needs. Systems | |
| | treatment was hand written on the Treatment record. The treatment was signed out as completed on 5/1/12, | | | | Changes: Competed by | |
| | | | | | 6/21/2012. | |
| | | | | | | |
| | 5/4/12, 5/7/12, 5/10/12, 5/13/12, 5/16/12, | | | | | |
| | | | | | | |
| | 5/19/12, 5/22/12 | , 5/15/12, and 5/28/12. | | | | |
| | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 35 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784 | A. BUILI | DING | NSTRUCTION 00 | (X3) DATE COMPL 05/30/ | ETED |
|--------------------------|--|---|----------|----------------------|---|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WING | STREET A 1420 E I | DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN 46545 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | a.m., the ADON treatment to the rediscontinued on a indicated the ord wound treatment transcribed onto Record. | indicated the wound right ankle area had been 4/28/12. The ADON der for the right ankle should not have been the 5/12 Treatment | | | | | |
| | reviewed on 5/29 resident's diagno not limited, to ur blood pressure, p disease and diaboresident was sent | o/12 at 11:00 a.m. The ses included, but were inary tract infection, high peripheral vascular etes mellitus. The to the hospital on med to the facility on | | | | | |
| | order form indicathe resident to remilligrams once a urinary tract in milligrams every milligrams twice | 2/12 patient transfer ated there were orders for ceive Levaquin 500 daily for 10 days to treat fection, Lipitor 80 night, Captopril 12.5 a day, and 25 milligrams once a | | | | | |
| | indicated the about written on the until 5/12/12. The | 2012 Medication Record eve four medications were e Medication Record he Lipitor was first en on 5/12/12. The | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet

Page 36 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: 155784 | A. BUILDING B. WING | | COMPLETED 05/30/2012 | | |
|--------------------------|--|--|---|--|----------------------|----|----------------------------|
| | PROVIDER OR SUPPLIER | EHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCED TO T | | E. | (X5) COMPLETION DATE |
| | | oril, and Spironaldactone out as given on 5/13/12. | | | | | |
| | resident's blood p were recorded at daily between 5/2 resident's blood p reading remained the resident. The reading recorded | ecord indicated the pressure and pulse rates 8:00 a.m. and 4:00 p.m. 2/12 and 5/12/12. The pressure and pulse I within normal range for thighest blood pressure was 170/81 on 5/5/12 gs averaging between | | | | | |
| | Summary report urinalysis was poinfection and the pending. The sur resident was start | 2/12 hospital Discharge indicated the resident's estitive for an urinary tract culture results were mmary also indicated the ted Levaquin 500 daily for ten days. | | | | | |
| | culture were not a record at the time of the culture and to the facility on request. The fin report was compleresults were position,000 proteus of The sensitivity results were results were position,000 proteus of the sensitivity results were positivity were positivity were positivity were positivity were positivity w | spital urinalysis and available in the resident's e of review. The results I sensitivity were faxed 5/29/12 at 2:26 p.m. per al culture and sensitivity leted on 5/4/2012. The tive for greater then mirabilis (an infection). Export indicated proteus istant to Levofloxacin | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 37 of 38

PRINTED: 06/25/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784 | | A. BUILDING B. WING | 00 | COMPLETED 05/30/2012 | | | | |
|---|---|--|---|---|----------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | p.m., the ADON orders written on medications and transcribed to the Record. | ed on 5/29/12 at 3:40 indicated there were in 5/2/12 for the above the orders were not en 5/2012 Medication relates to Complaint | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PYKT11

Facility ID: 012329

If continuation sheet Page 38 of 38